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Submission and Review of Rates for Medicare Supplement Insurance

Sec. 38a-474-1. Definitions

As used in Sections 38a-474-1 to 38a-474-4, inclusive, of the regulations of Connecticut state agencies:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Insurer" means insurance company, fraternal benefit society, hospital service corporation, medical service corporation, or health care center.

(3) "Medicare supplement policy" means any Medicare supplement policy or certificate, as defined in Sections 38a-495, 38a-495a and 38a-522 of the general statutes, delivered, issued for delivery, continued or renewed in this state on or after October 1, 1990 by any insurer.

(Adopted effective November 28, 1995)

Sec. 38a-474-2. Rate submission requirements

(a) Each insurer shall submit the rates on every Medicare supplement policy form for initial approval by the Commissioner and annually thereafter.

(b) An insurer seeking to change rates on a Medicare supplement policy form shall submit the revised rates to the insurance department at least sixty days prior to the proposed effective date of the change. The department shall review the revised rates and, with respect to any request for an increase in rates, shall hold a public hearing on such request in accordance with the department's rules of practice. The commissioner shall approve or deny any request for a change in rates on a Medicare supplement policy form within forty-five days of its receipt.

(c) Where an insurer does not seek to change rates for a policy form, the insurer shall submit the previously approved rates at least forty-five days before the expiration of twelve months from the effective date of those rates. The commissioner shall either approve the continued use of such rates or notify the insurer that premium adjustments are necessary to achieve the appropriate loss ratio. If the insurer fails to make premium adjustments acceptable to the commissioner, the commissioner shall order premium adjustments, refunds or premium credits necessary to achieve the appropriate loss ratio.

(d) All submission of rates for Medicare supplement policy forms shall be made in duplicate, accompanied by a postage paid return envelope of sufficient size to accommodate the filing. An Actuarial Memorandum describing the basis on which rates were determined shall accompany the submission and shall include the following items:

(1) The policy form number for which rates are being submitted.

(2) A cover letter that includes a description of the form in sufficient detail to accurately illustrate its benefits and terms.

(3) The method of marketing used. A statement that the policy form is actively offered for sale. If a policy has been discontinued, the date when sales ceased shall be stated.

(4) The rates appropriate for the state, including all modal factors. The assumed period for which the rates are to be effective should be stated.

(5) The explicit assumptions and factors used in calculating the community rate. These shall include, but are not limited to, any loads for the guaranteed issue requirement, the required offering to the disabled or the automatic crossover system (piggybacking). Experience rating by case is not allowed for group policies.

(6) A statement of the anticipated loss ratio over the total lifetime of the policy. A demonstration that the minimum loss ratio requirements of 65% for individual

policies and 75% for group policies will be met. Such demonstration shall exclude active life reserves.

(7) The expected future loss ratio projected through the period for which the rates will be effective. An expected third-year loss ratio which is greater than or equal to the applicable loss ratio standard shall be demonstrated for policies or certificates in force less than three years.

(8) A statement signed by a member of the American Academy of Actuaries or another individual acceptable to the commissioner, certifying that: the loss ratios are in compliance with section 38a-495 (b) or section 38a-522 (b) of the general statutes, or section 38a-495a-10 of the regulations of state agencies, as appropriate; the calculations were made in accordance with actuarial standards of practice; the premiums are neither excessive nor inadequate; and the premiums are reasonable in relation to benefits. The address and phone number of the actuary should be stated on the certification.

(9) A demonstration that the rates do not incorporate factors for expenses which exceed one hundred fifty per cent of the average expense ratio for the entire written premium for all of the insurer's lines of health insurance for the previous calendar year in accordance with section 38a-473 of the general statutes. The average expense factor shall be calculated from Schedule H (Accident and Health Exhibit) of the prior year's annual financial statement, as the ratio of A to B where:

A is equal to the Total General Insurance Expenses (excluding taxes, licenses and fees), and

B is equal to the Total Premiums Written.

(10) If the insurer currently sells Medicare supplement policies in this state, a demonstration that the insurer makes at least standardized Plan A available to persons eligible for Medicare by reason of disability. For group filings, a description of the eligibility requirements of the group that includes at a minimum identification of the policyholder, requirements for membership and the purpose of the group.

(11) For forms where underwriting is permitted, a general statement of underwriting limitations.

(12) A table showing amounts proposed to be charged to consumers if the rates are approved as submitted.

(13) Such additional information as the commissioner may deem necessary for an adequate review of the proposed rates.

(e) The Actuarial Memorandum accompanying a submission of revised rates shall include in addition to the information required under subsection (c) the following items:

(1) The policy inforce count and the age/sex distribution both statewide and nationwide for the policy form.

(2) For each policy form, for each calendar year since inception, both statewide and nationwide: incurred claims; earned premium including modal loadings and policy fees; and resulting loss ratios. All claim and premium figures shall reflect actual experience to date.

(3) A history of rate changes for the policy form in Connecticut, including the effective date and magnitude of each previous rate change.

(4) Such additional information as the commissioner may deem necessary for an adequate review of the proposed revised rates.

(Adopted effective November 28, 1995)

Sec. 38a-474-2a. Electronic filing

(a) Any insurer filing rates with the commissioner in accordance with section 38a-474-2 of the Regulations of Connecticut State Agencies may submit such filing

electronically using software known as the System for Electronic Rate and Form Filing (SERFF), Version 2.0 or higher, or any subsequent corresponding system, adopted by the National Association of Insurance Commissioners. All such filings shall include the information required in section 38a-474-2 of the Regulations of Connecticut State Agencies.

(b) Filings made electronically shall be considered received by the commissioner when received at the Insurance Department. Filings received on a weekend or legal holiday shall be deemed received on the next business day. An electronic communication from the Insurance Department concerning a filing shall be deemed received by the person to whom the communication is addressed when the communication is sent to that person.

(Adopted effective January 2, 2002)

Sec. 38a-474-3. Rate review standards

(a) The commissioner shall not approve a rate for a Medicare supplement policy that is excessive, inadequate, unreasonable in relation to the benefits provided or unfairly discriminatory.

(b) Rates for Medicare supplement policy or certificate forms shall not be approved unless the form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders or certificate holders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form:

(1) at least seventy-five (75%) of the aggregate amount of premiums earned in the case of group policies, or

(2) at least sixty-five percent (65%) of the aggregate amount of premiums earned in the case of individual policies, calculated on the basis of incurred claims experience, or incurred health care expenses where coverage is provided by a health care center, and earned premiums for such period and in accordance with accepted actuarial principles and practices. All rate filings shall demonstrate that expected claims in relation to premiums comply with these loss ratio requirements when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate required loss ratio.

(Adopted effective November 28, 1995)

Sec. 38a-474-4. Separability

If any provision of sections 38a-474-1 to 38a-474-3, inclusive, of the regulations of Connecticut state agencies or the application thereof to any person or circumstance is for any reason held to be invalid, the remainder of this regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

(Adopted effective November 28, 1995)